Welcome to . Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State Zip

Social Security Number | Date of Birth | Home Phone | Cell Phones | Ok to text? ○ Yes ○ No

Email Address | Guardian | Person Responsible for Account

Emergency Contact | Emergency Phone

☐ American Indian Or Alaska Native
☐ Asian
☐ Black Or African American
☐ Hispanic Or Latino
☐ Native Hawaiian Or Other Pacific Islander
☐ White
☐ Declined To Specify
Other Race

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company | City | State Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company | City | State Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Name

Payment Policy

Payments are due in full at the time services are rendered unless other arrangements are made prior to the exam. We accept **CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, AND CARE CREDIT.**

_____
Initial

Insurance Policy

Our staff will be happy to assist you in submitting and processing your claims, however, it is ultimately your responsibility to know what your medical or vision plan covers. Please check your policy to determine your coverage prior to your exam. All copays and patient expected responsibilities are due the day services are rendered. The undersigned is responsible for any bill incurred in this office. Payment from my insurance company is to be paid directly to Nova Eye Care. I understand that all benefits quoted are not a guarantee of payment by my insurance company and that final determination can not be made until my claim is fully processed.

_____ _____ _____
Patient Signature of responsible party Date

"Medical" vs. "Routine"

For insurance purposes, eye examinations are classified as either "medical" or "routine". Your medical history, current symptoms, and examination findings will determine how your visit will be coded. As with any medical visit, your usual copay and deductible may apply. Some services, including refraction and contact lens exam fees, may not be covered.

Your visit will be coded "medical" if any of the following apply:

* headaches, eye pain, itching, tearing, redness, dry eye, sudden vision changes, double vision, light sensitive, floaters, etc.
*medical eye conditions-cataract, glaucoma, macular degeneration
*medical conditions- diabetic, rheumatoid arthritis, and other medical conditions
*you are diagnosed with a medical eye condition during your exam

Routine:

*if none of the above apply to you, this constitues a "routine", well vision exam. During your "routine" exam, your eyes will be examined for any needed corrections (glasses, contacts, etc.) and screened for potential indicators of eye disease.

Please note: Each visit is documented in your medical record and a diagnosis is made by your provider based on medical information, not based on coverage by your insurance company. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier considered insurance fraud and will not be done by our office.

Cancellations/No shows

_____
Initial

Late cancellations (less than 24 hours notice) and "no shows" will be subject to a $25 fee. An individual who "no shows" inconvenience others who need access to medical care in a timely manner.

NOTICE OF PRIVACY POLICY

You may read our privacy policy in it's entirety on our website at **NOVAEYECARE.NET**

Notice of Privacy Practices Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting Nova Eye Care at 336-625-2020 or by visiting our website. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. we are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Signature_____ Date:_____

Dilation Consent

___I give consent to have my eyes dilated today

___I do not wish to have my eyes dilated today

_____
Initial

Name

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? When was your last exam ?

Past Eye Illnesses/Injury

Past Eye Surgeries:

Current Medications:

Current Eye Drops:

Medication Allergies:

EYE HISTORY

Glaucoma	○ Yes	○ No	Dryness	○ Yes	○ No	Strabismus (Crossed Eyes)	○ Yes	○ No
Cataract	○ Yes	○ No	Excess Tearing/Watering	○ Yes	○ No	Blurred Vision Distance	○ Yes	○ No
Macular Degeneration	○ Yes	○ No	Eye Pain or Soreness	○ Yes	○ No	Blurred Vision Near	○ Yes	○ No
Retinal Detachment	○ Yes	○ No	Foreign Body Sensation	○ Yes	○ No	Distorted Vision (halos)	○ Yes	○ No
Color Blindness	○ Yes	○ No	Infection of Eye or Lid	○ Yes	○ No	Double Vision	○ Yes	○ No
Headaches	○ Yes	○ No	Itching	○ Yes	○ No	Floaters or Spots	○ Yes	○ No
Glare/Light Sensitivity	○ Yes	○ No	Mucous Discharge	○ Yes	○ No	Fluctuating Vision	○ Yes	○ No
Tired Eyes	○ Yes	○ No	Drooping Eyelid	○ Yes	○ No	Blind	○ Yes	○ No
Amblyopia (Lazy Eye)	○ Yes	○ No	Redness	○ Yes	○ No	Loss of Side Vision	○ Yes	○ No
Burning	○ Yes	○ No	Sandy or Gritty Feeling	○ Yes	○ No			

GENERAL HEALTH CONDITION

Pregnant	○ Yes	○ No	Respiratory (Asthma)	○ Yes	○ No	Anxiety or Depression	○ Yes	○ No
Nursing	○ Yes	○ No	Gastrointestinal	○ Yes	○ No	Thyroid	○ Yes	○ No
Diabetes	○ Yes	○ No	Kidney	○ Yes	○ No	Blood/Lymph	○ Yes	○ No
Sinus	○ Yes	○ No	Muscles,Bones,Joints	○ Yes	○ No	Allergic	○ Yes	○ No
Cardiovascular (high blood pressure etc.)	○ Yes	○ No	Skin	○ Yes	○ No	STD's	○ Yes	○ No
			Neurological (Multiple Sclerosis)	○ Yes	○ No	Explain:		

FAMILY HISTORY

Amblyopia (Lazy Eye)	○ Yes	○ No	Retinal Detachment	○ Yes	○ No	High Blood Pressure	○ Yes	○ No
Blindness	○ Yes	○ No	Strabismus (Eye Turn)	○ Yes	○ No	Kidney Disease	○ Yes	○ No
Cataract(s)	○ Yes	○ No	Arthritis	○ Yes	○ No	Lupus	○ Yes	○ No
Color Blindness	○ Yes	○ No	Cancer	○ Yes	○ No	Stroke	○ Yes	○ No
Glaucoma	○ Yes	○ No	Diabetes	○ Yes	○ No	Thyroid Disease	○ Yes	○ No
Macular Degeneration	○ Yes	○ No	Heart Disease	○ Yes	○ No	MS	○ Yes	○ No

SOCIAL HISTORY

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Method of Tobacco Intake : ○ Smoking ○ Chewing

Do you use Illegal Drugs : ○ Yes ○ No